

907 KAR 1:360. Preventive and remedial public health services.

RELATES TO: KRS 205.520, 205.560, 42 C.F.R. 431.615

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 42 U.S.C. 1396a, b, c, d

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry. This administrative regulation establishes the provisions relating to preventive and remedial public health services provided through the Department for Public Health and the method of reimbursement for these services by the Kentucky Medicaid Program.

Section 1. Definitions. (1) "Add-on code" means a designated CPT code which may be used in conjunction with another CPT code to denote that an adjunctive service has been performed.

(2) "CPT code" means a code used for reporting procedures and services performed by physicians or other licensed medical professionals which is published annually by the American Medical Association in Current Procedural Terminology.

(3) "Department" means the Department for Medicaid Services or its designated agent.

(4) "Incidental" means that a medical procedure:

(a) Is performed at the same time as a more complex primary procedure; and

(b)1. Requires few additional physician resources; or

2. Is clinically integral to the performance of the primary procedure.

(5) "Integral" means that a medical procedure represents a component of a more complex procedure performed at the same time.

(6) "KenPAC" means the Kentucky Patient Access and Care System.

(7) "KenPAC PCP" means a Medicaid provider who is enrolled as a primary care provider in the Kentucky Patient Access and Care System.

(8) "Medically necessary" or "Medical necessity" means a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(9) "Mutually exclusive" means that two (2) procedures:

(a) Are not reasonably performed in conjunction with one (1) another during the same patient encounter on the same date of service;

(b) Represent two (2) methods of performing the same procedure;

(c) Represent medically impossible or improbable use of CPT codes; or

(d) Are described in current procedural terminology as inappropriate coding of procedure combinations.

(10) "Relative value unit" or "RVU" means the Medicare-established value assigned to a CPT code which takes into consideration the physician's work, practice expense, and liability insurance.

(11) "Screening" means the evaluation of a recipient by a physician to determine:

(a) The presence of a disease or medical condition; and

(b) The necessity of further evaluation, diagnostic tests or treatment.

Section 2. Participation Requirements. (1) The Department for Public Health shall comply with the terms and conditions established in the following administrative regulations:

(a) 907 KAR 1:005, Nonduplication of payments;

(b) 907 KAR 1:671, Conditions of Medicaid provider participation; withholding overpayments, administrative appeal process, and sanctions; and

(c) 907 KAR 1:672, Provider enrollment, disclosure, and documentation for Medicaid participa-

tion.

(2) The Department for Public Health shall comply with the requirements regarding the confidentiality of personal medical records as mandated by 42 U.S.C. 1320d to 1320d-8 and 45 C.F.R. Parts 160 and 164.

Section 3. Covered Services. The following medically-necessary preventive, screening, diagnostic, rehabilitative and remedial services provided by the Department for Public Health directly or indirectly through its subcontractors shall be covered:

- (1) A chronic disease service;
- (2) A communicable disease service;
- (3) An early and periodic screening, diagnosis, and treatment (EPSDT) service;
- (4) A family planning service;
- (5) A maternity service; or
- (6) A pediatric service.

Section 4. Service Limitations. (1) A laboratory procedure shall be limited to a procedure for which the provider has been certified in accordance with 42 C.F.R. Part 493.

(2) A service allowed in accordance with 42 C.F.R. 441, Subpart E or Subpart F shall be covered within the scope and limitations of these federal regulations.

(3) Coverage for a fetal diagnostic ultrasound procedure shall be limited to two (2) per nine (9) month period per recipient unless the diagnosis code justifies the medical necessity of an additional procedure.

(4) Except for a service specified in 907 KAR 1:320, Section 10(3)(a) through (q), a referral from the KenPAC PCP shall be required for a recipient enrolled in the KenPAC Program.

Section 5. Reimbursement. (1) Payment for a preventive health service specified in Section 3(1) through (6) of this administrative regulation shall be calculated by multiplying the current Medicare conversion factor for Kentucky by the nonfacility relative value unit weight for the procedure code.

(2) For a service covered under Medicare Part B, reimbursement shall be in accordance with 907 KAR 1:006.

(3) If a copayment is required in accordance with 907 KAR 1:604, reimbursement shall be reduced by the amount of the copayment.

(4) If performed concurrently, separate reimbursement shall not be made for a procedure that has been determined by the department to be incidental, integral, or mutually exclusive to another procedure.

(5) Except for an applicable add-on code, reimbursement for an anesthesia service shall be limited to one (1) CPT code and one (1) unit of anesthesia per operative session.

(6) Reimbursement for a surgical procedure shall include the following:

- (a) A preoperative service;
- (b) An intraoperative service;
- (c) A postoperative service and follow-up care:
 1. Within ninety (90) days following the date of major surgery; or
 2. Within ten (10) days following the date of minor surgery; and
- (d) A preoperative consultation performed within two (2) days of the date of the surgery.

Section 6. Audits. (1) The Department for Public Health or subcontracting local health departments shall provide to the Department for Medicaid Services or a representative of an agency or office listed in subsection (2) of this section, upon request:

- (a) Information maintained by the provider to document the service provided;
 - (b) Information regarding a payment claimed by the provider for furnishing a service; or
 - (c) Information documenting the cost of the service.
- (2) Access to provider or subcontractor records relating to a service provided shall be required for:
- (a) A representative of the United States Department of Health and Human Services;
 - (b) The United States Centers for Medicare and Medicaid Services;
 - (c) The United States Attorney General's Office;
 - (d) The state Attorney General's Office;
 - (e) The state Auditor's office;
 - (f) The Office of the Inspector General; or
 - (g) An agent or representative as may be designated by the Secretary of the Cabinet for Health Services.

Section 7. Appeal Rights. (1) An appeal of a department decision regarding a Medicaid provider based upon an application of this administrative regulation shall be in accordance with 907 KAR 1:671.

(2) An appeal of a department decision regarding a Medicaid recipient based upon an application of this administrative regulation shall be in accordance with 907 KAR 1:563.

(3) An appeal of a department decision regarding Medicaid eligibility of an individual shall be in accordance with 907 KAR 1:560. (15 Ky.R. 768; eff. 10-21-88; Am. 25 Ky.R. 1257; 1662; eff. 1-19-99; 28 Ky.R. 961; eff. 12-19-2001; 29 Ky.R. 1140; 1656; eff. 12-18-02; 30 Ky.R. 463; 887; eff. 10-31-03; 31 Ky.R. 2052; 32 Ky.R. 272; eff. 8-25-05.)